

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(157)

00799

CERTIFICATE OF DEATH

Reg. Dist. No. 2 PZ

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

D. Maryland Hospital —
Peters

How long in hospital or institution?

3. (a) FULL NAME

Infant Abee

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m

W

—

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Jan 27/45 —

8. AGE: Years

Months

Days

If less than one day

6

hrs.

min.

9. Birthplace.....

Md

(Town, county, and state)

10. Usual occupation.....

—

11. Industry or business

FATHER

12. Name.....

Audrey Johnson

13. Birthplace

Md

MOTHER

14. Maiden name.....

Mary Louise Wood

15. Birthplace

Md

16. Informant.....

Mary Louise Abee

Address

Haleylewood

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof, 1-28/45

(month) (day) (year)

Cemetery or crematory

St. Agnes

Location

Haleylewood

18. Funeral director.....

W.C. Neary, Sons

Address

Baltimore Md

19. (Date rec'd by registrar)

1/28 45 - Cœcules

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

H. Maryland

City or town

Haleylewood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 27 45 - 8-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from

Jan 27 45 18 to Jan 27 1945

and that I last saw h. alive on

Jan 27 1945

Immediate cause of death.....

Pneumonitis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

7

Injured at work?

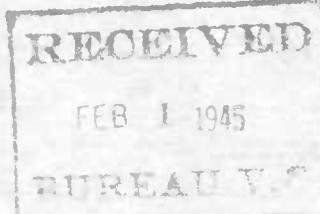
23. SIGNATURE.....

M. D. or other

Address

Haleylewood

Date signed 1/28/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1000

CERTIFICATE OF DEATH

Reg. Dist. No. 282

00800

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

about 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

1 day

3. (a) FULL NAME

John Henry Bond

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored married

6. (b) Name of husband or wife Mary C Bond

7. Birth date of deceased (mo., day, yr.) Aug 28 1897

8. AGE: Years Months Days If less than one day

27 4 17 hrs. min.

9. Birthplace Mechanicsville MD

(Town, county, and state)

Laborer

10. Usual occupation

—

11. Industry or business

—

12. Name Joseph Bond

13. Birthplace St Mary's Co

14. Maiden name Nannie Briscoe

15. Birthplace St Mary's Co

16. Informant Mary C Bond

Address Charlotte Hall MD

Burial

Date thereof Jan 17 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Joseph

Location Morgantown MD

18. Funeral director W E McMillen & Sons

Address Leonardtown MD

19. Date rec'd by registrar Jan 16 1945

Signature Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Mary's

City or town Charlotte Hall MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

214-16-8864

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I examined deceased from

19... on Jan 14 1945

and that I last saw him alive on 18...

Immediate cause of death Fractured skull

DURATION 10 hrs

Due to Fractured skull

Due to Having been hit by

Automobile

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Occident Date of Jan 14 1945

Where did injury occur? Charlotte Hall MD

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Auto Highway

Means of injury Automobile Injured at work? No

23. SIGNATURE Francis F. Gurnell

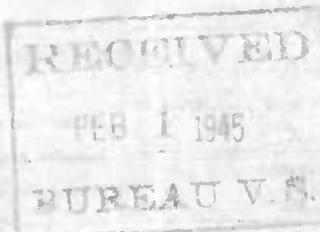
M. D. or other

Address Leonardtown MD Date signed Jan 16 1945

RELAY TO TRANSMIT STATE INFORMATION

TO THE SECRETARY OF STATE

HTABD TO BE AUTHORIZED



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

00891

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County

St. Mary's Co
Valley Lee 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Evelyn Biscoe

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

color

Widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

1817

8. AGE: Years Months Days If less than one day

67

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

House Keeper

11. Industry or business

12. Name.....

Evelyn Biscoe

13. Birthplace.....

St. Mary's Co

14. Maiden name.....

Adeline Biscoe

15. Birthplace.....

St. Mary's Co

16. Informant.....

Violet Biscoe

Address

134 S. Caroline St Baltimore

17. Burial.....

Date thereof Jan 20 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. Mary's

Location.....

Valley Lee 2nd

18. Funeral director.....

W.C. Matthews Sons

Address

Leonardtown MD

19. Date rec'd by registrar

1945

(Date rec'd by registrar)

B. Beary M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County St. Mary's

City or town

Valley Lee (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

January 18 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 6 1945 to Jan 16 1945 and that I last saw her alive on Jan 16 1945

and that I last saw her alive on Jan 16 1945

Immediate cause of death.....

Congestive Heart Failure

DURATION 5 days

Due to..... Hypertension, Malignant

2 years

Due to..... Tuberculosis -

12 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

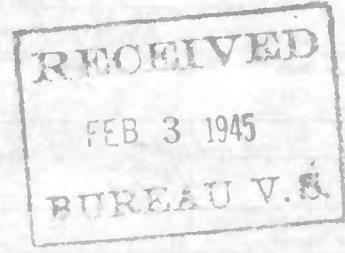
Injured at home, farm, Industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Pearson and 1-19-X5 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

00802

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

St. Marys

County.....

Leonardtown

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Alms House

How long in hospital or institution?.....

1 yr.

3. (a) FULL NAME

Lucy Bush

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

colored

married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Unknown

6. (c) If alive, give age years

8. AGE:

Years
73 ?

Months

Days

If less than one day

..... hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

MOTHER FATHER

12. Name.....

Clem Beal

13. Birthplace.....

Maryland

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Peter Beal

Address.....

Ridge, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

St. Peters

Cemetery or crematory.....

Ridge, Maryland

Location.....

Ernest L. Robinson

18. Funeral director.....

Address.....

Dameron Md.

19. Date rec'd by registrar

19.

Cause(s)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

St. Marys

City or town.....

Park Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 2nd 1945 at 6:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 1944, to Jan 2nd 1945
and that I last saw her alive on Jan 2nd 1945

Immediate cause of death.....

Fibrillating Heart

Due to.....

Hyperacute Chronic

DURATION

Due to.....

Atherosclerosis

8 mos

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

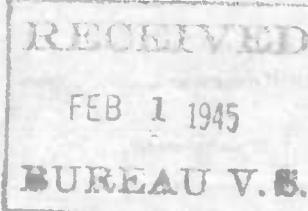
Injured at work?

23. SIGNATURE.....

J. F. Greenwell
Leonardtown, Md. Date signed Dec 6-45
M. D. or other

STATE OF TEXAS STATE CHAIRMAN

HEARD & STAFFED



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of age of deceased is shown
FILE No. G 92 MAR 10 1943

1. PLACE OF DEATH

County *St. Marys*Village or City *Mechanicsville*

726

Registration Dist. N. D.

284

St., Ward

Length of residence in city or town where death occurred *6 yrs.* mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.2. FULL NAME *James Edward Moore* If U. S. Veteran, specify WAR

(a) Residence: N. D.

St., Ward.

If nonresident give city or town and State

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>Wh.</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
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5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of *Alexander Gaywood*

6. DATE OF BIRTH (month, day, and year) *Aug 21 1866*

7. AGE	Years <i>78</i>	Months <i>7</i>	Days <i>27</i>	If LESS than 1 day, _____ hrs. or _____ min.
--------	-----------------	-----------------	----------------	--

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BODKKEEPER, etc. *None*
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) *Charles Co. Md.*
(State or country)13. NAME *James Edward Moore*14. BIRTHPLACE (city or town) *Charles Co. Md.*
(State or country)15. MAIDEN NAME *Mary Eliza Hancock*16. BIRTHPLACE (city or town) *Charles Co. Md.*
(State or country)17. INFIRMARY *Mary Eliza Hancock Co. Charles Co. Md.*
(Address)18. BURIAL, CREMATION, OR REMOVAL
Place *Charles Co. Md.* Date *Jan 23, 1945*19. UNDERTAKER *Mrs. Rose E. Welch*
(Address)20. FILED *Jan 22, 1945* Signed *J. H. Johnson*
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH *Jan 21, 1945*

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

1840, 19, to *Jan 21, 1945*, 1945I last saw him alive on *Sept*, 1944; death is said to have occurred on the date stated above, et m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Mr. Wal Simpson

Date of onset

Other Contributory Causes of importance:

Arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) *J. H. Johnson* M. D.
(Address) *Charles Co. Md.*

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

77-C

00804

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County.....

City or town.....

*St. Mary's
Holly wood Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 3 years*

Hospital, Institution, or street address where death occurred? *Rural*

How long in hospital or institution? *2 3 year*

3. (a) FULL NAME

Jos A. Clarke

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male White married

B. (b) Name of husband or wife.....

Agnes J. Gospay

7. Birth date of deceased (mo., day, yr.) *July 18 1904*

6. (c) If alive, give age.....

years

8. AGE: Years *40* Months *6* Days *8*

If less than one day

hrs. min.

9. Birthplace *Holly wood St. Mary's Md*

(Town, county, and state)

10. Usual occupation *Clerk*

11. Industry or business

12. Name *charles clarke*13. Birthplace *Holly wood Md*14. Maiden name *Della abell*15. Birthplace *Holly wood Md*16. Informant *charles clarke*Address *Holly wood Md*17. Burial Date thereof *Burial Jan 27 1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *St. Joseph Cemetery*Location *Holly wood Md*18. Funeral director *W C Matheny Sons*Address *Lionshead Rd St. Mary's Md*19. Date rec'd by registrar *Jan 24 1945*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *St. Mary's*City or town *Holly wood Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 25* 1945 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 23 1945 to Jan 25 1945*and that I last saw him alive on *Jan 25 1945*.Immediate cause of death *Acute Alcoholism*

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

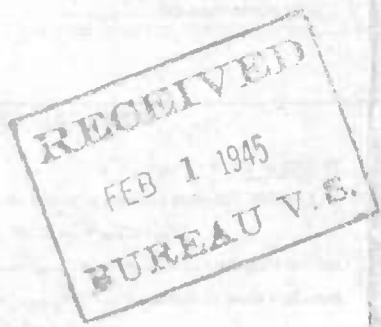
23. SIGNATURE *J. F. Greenwell M.D.*

M. D. or other

Address *St. Mary's Md* Date signed *Jan 26 1945*

RECEIVED IN THE UNITED STATES GOVERNMENT

LIBRARY OF CONGRESS



1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00805

140

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County St. MarysCity or town Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rebecca Deliah Davis4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct 8 1859 6. (c) If alive, give age years8. AGE: Years 85 Months 3 Days 19 If less than one day hrs. min.9. Birthplace St. Marys Co (Town, County, and state)10. Usual occupation none

11. Industry or business

12. Name Farmwife Davis13. Birthplace Lehigh Co Pa14. Maiden name Caroline Gaskay15. Birthplace St. Marys Co Md16. Informant Charles CalmaAddress Medicationist for17. Burial Cremation Date thereof Dec 30 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory All FaithsLocation New Market Rd18. Funeral director Elmer J. GeorgeAddress Hagerstown Md19. Date rec'd by registrar Jan 2 84 1945 Date signed Jan 2 84 Registrar Lynn S. Hartman

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St. MarysCity or town Near Mechanicsville Md (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 84 1945 at 2:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1945 to Jan 2 84 1945, and that I last saw her alive on Dec 30 1945.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions Pregnancy delivered (Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Lynn S. Hartman M. D. or other Elmer J. GeorgeAddress Hagerstown Md Date signed Jan 2 84



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 510

00806

CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH: St. Marys
 County: Chaptico
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Live time
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: St. Marys
 City or town: Chaptico P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Thomas Leni Davis

4. Sex: Male	5. Color or race: white	6.(a) Single, married, widowed, or divorced: Single
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6.(b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) March 7th 1864

(c) If alive, give age years

8. AGE: Years: 80	Months: 10	Days: 2	If less than one day: hrs: min:
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9. Birthplace: St. Marys Co., Maryland
 (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: _____

12. Name: Leni Davis

13. Birthplace: St. Marys Co., Md.

14. Maiden name: Catherine Hayden

15. Birthplace: St. Marys Co., Md.

16. Informant: James Ed. Davis

Address: Chaptico, Maryland

Burial Date thereof: Jan - 11 - 1945

(Burial, cremation, or removal? Which?) Cemetery or crematory: Christ Church

Location: Chaptico, Maryland

18. Funeral director: Rose E. Welch

Address: Chaptico, Maryland

Date rec'd by registrar: Jan. 10 1945

Registrar: A. J. Johnson

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1945 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1944 to Jan. 9 1945 and that I last saw him alive on Jan. 9 1945.

Immediate cause of death:

Carcinoma Prostate

Due to: ?

Due to: _____

Other conditions: Cardiorenal Vascular disease -

(Include pregnancy within 8 months of death)

Major findings of operations: none done

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Aleysus C. Welch M.D.

M. D. or other: _____

Address: Chaptico, Maryland Date signed: 1/10/45

RECEIVED
FEB 6 1945
BUREAU V.S.

M

1 MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-0

00807

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County *St. Marys'*City or town *Hagerstown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *0 hours*

3. (a) FULL NAME

*Joseph Carroll Yass*4. Sex *Male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Married*B. (b) Name of husband or wife *Ella Collins Yass*7. Birth date of deceased (mo., day, yr.) *May 27 1881* 6. (c) If alive, give age *59* years8. AGE: Years *63* Months *7* Days *16* If less than one day hrs. min.8. Birthplace *Palmer's St. Marys Co Md*
(Town, county, and state)10. Usual occupation *Waitress*

11. Industry or business

12. Name *Robert Yass*13. Birthplace *Berman*14. Maiden name *Mary Jane Morris*15. Birthplace *St. Marys Co*16. Informant *Mrs. Ella Collins Yass*Address *Palmer's Md*17. Burial Date thereof *Jan. 18 1945*
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory *St. Paul's*Location *Buck Wood Md*18. Funeral director *W. C. Mattaway Sons*Address *Leonardtown Md*19. Date rec'd by registrar *Jan 11 1945*Date rec'd by registrar *Jan 11 1945*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *St. Marys*City or town *Palmer's* (If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2d. DATE OF DEATH *Jan 1 1945* at *7:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *one Jan. 8 1945* to *1945*, and that I last saw him alive on *Jan. 8 1945*.

Immediate cause of death

Subarachnoid Hemorrhage

DURATION

*12 hours*Due to *Hypertension*Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Joe H. Palmer*

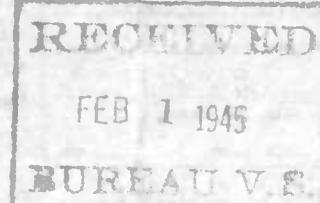
M. D. or other

Address *Pearson Md* Date signed *1-10-45*

VS A15

RECEIVED
FEB 1 1946

CERTIFICATE OF MAIL



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

CERTIFICATE OF DEATH

00808

Reg. Dist. No. 2 S-2

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hospital
2nd flr.

How long in hospital or institution?

3. (a) FULL NAME

Infant Gray

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m w -

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan. 27 1945

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

2 hrs. min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Jos. P. Gray

Veneer

Baptist Church

16. Informant

Jos. P. Gray

Address

Galveston Rd. S. MD

17. Burial, cremation, or removal. Which?

Date thereof 1-28-45

(month) (day) (year)

Cemetery or crematory

St. Alphonsus

Location

Baltimore

18. Funeral director

W.C. Mullings

Address

Forward from S. MD

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

County

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 27 1945 to Jan. 27 1945

and that I last saw him alive on Jan. 27 1945

Immediate cause of death.....

Prematurity

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

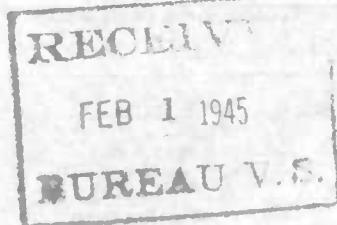
23. SIGNATURE

Frank O. Canale

M. D. or other

Address

Date signed 1/28/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

00809

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County

City or town

St. Mary's

Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3 Weeks

3. (a) FULL NAME

William F. Greenwell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife

Estelle P. Greenwell

7. Birth date of deceased (mo., day, yr.)

Jan 30, 1897

8. (c) If alive, give age 49 years

8. AGE:

Years

Months

Days

If less than one day

47 11 16 hrs. min.

6. Birthplace

Leonardtown, St. Mary's Co., Md.

(Town, county, and state)

10. Usual occupation

Barber

11. Industry or business

none

MOTHER

FATHER

12. Name

Jos H. Greenwell

13. Birthplace

St. Mary's Co.

14. Maiden name

Ada E. Jones

15. Birthplace

St. Mary's Co.

16. Informant

Mrs. Estelle P. Greenwell

Address

Leonardtown, Md.

17. Burial

Date thereof Jan 17, 1945

(month) (day) (year)

Cemetery or crematory

St. Joseph Cemetery

Location

Morganza Mill

18. Funeral director

W C Hollingsley Sons

Address

Leonardtown, Md.

19. (Date rec'd by registrar)

1/16/45

1945

Cause of death

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County St. Mary's

City or town

Leonardtown (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 15 1945 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1944 to Jan 15 1945

and that I last saw him alive on Jan 14 1945

Immediate cause of death

Cerebral Liquefaction

Due to

Due to

Other conditions Acute Myocardial Failure

(Include pregnancy within 8 months of death)

Major findings of operations none done

Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

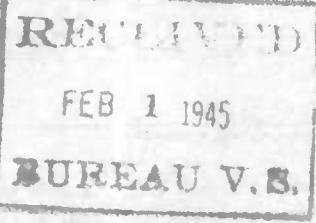
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alvin C. Welch M.D.

M. D. or other Chapter MD

Address Date signed Jan 16, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9B1

00810

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County.....

City or town.....*St. Mary's
Rural Clermont*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *4 days*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Louis Knott

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *7-12-1882*

8. AGE:

Years Months Days If less than one day

62 5 27 hrs. min.

9. Birthplace.....*Chas Co. Md.*
(Town, county, and state)10. Usual occupation.....*Passing*

11. Industry or business.....

12. Name.....*John Edward Knott*13. Birthplace.....*Chas Co. Md.*14. Maiden name.....*Mary Frances Barber*15. Birthplace.....*Chas Co. Md.*16. Informant.....*John Louis Knott*Address.....*St. Mary's Rural Clermont*17. Burial.....*Burial*

(Burial, cremation, or removal. Which?)

Date thereof.....*1-11-44*
(month) (day) (year)Cemetery or crematory.....*Sacred Heart*Location.....*Baltimore*18. Funeral Director.....*Robinson Books*Address.....*Lowellton and*19. Date rec'd by registrar.....*1-9-44* 19. Date signed.....*1-9-44*
(Date rec'd by registrar) (Date signed)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....*St. Mary's*
City or town.....*Rural Clermont*
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*1-11-44*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on *dead 1-8-44*Immediate cause of death.....*Cerebral**apoplexy*

Due to.....

Due to.....

Other conditions.....*Chronic rheumatic 10 yrs.*

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....*Robert V. Palmer*

M. D. or other

Address.....*annexed* Date signed.....*1-9-44*

RECEIVED BY THE UNITED STATES GOVERNMENT
GENERAL INSPECTORATE
ATTACHÉ OF THE UNITED STATES

RECEIVED
MAR 6 1945
BUREAU V.S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00811

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County St. Marys
 City or town Rural St. James
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Frank Sewell

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Black	Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9 1890

8. AGE: Year	Months	Days	If less than one day
54	2	?	hrs. min.

9. Birthplace St. Marys City
 (Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER	12. Name.....	<u>John Sewell</u>
	13. Birthplace	<u>St. Marys Co. Md.</u>

14. Maiden name.....	<u>Sylvia Butler</u>
15. Birthplace	<u>St. Marys Co. Md</u>

16. Informant.....	<u>Lily Millburn</u>
Address	<u>St. Marys City, Md.</u>

17. Burial	Date thereof.....	<u>1-16-45</u>	
(Burial, cremation, or removal. Which?)	(month)	(day)	(year)

Cemetery or crematory	<u>Trinity Cemetery</u>
Location	<u>St. Marys City</u>

18. Funeral director.....	<u>E. L. Robinson</u>
Address	<u>Dameron, Md</u>

19. (Date rec'd by registrar)	<u>1-15-45</u>	<u>P. J. Bean</u>	Local	Registrar
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2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
 City or town Rural St. Marys City
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Jan 14 1945 end that I last saw him alive on Jan 13 1945.

Immediate cause of death.....

Bronchitis - pneumoniaDue to Acute bronchitis

DURATION

2 days
1 week

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

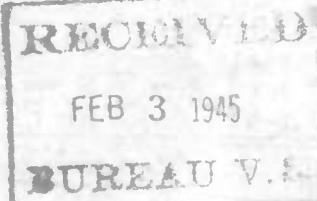
Injured at work?

23. SIGNATURE.....

P. J. Bean M.D. M. D. or other

Address.....

Great Mills Md. Date signed 1-15-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00812

CERTIFICATE OF DEATH

Reg. Dist. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County St. Marys
 City or town Rural Callaway
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Philip Otha Smith

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male Black single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 11-17-1944

6.(c) If alive, give age years

8. AGE: Years 1 Months 1 Days 25 If less than one day hrs. min.9. Birthplace Callaway
(Town, county, and state)10. Usual occupation /11. Industry or business /12. Name Otha Smith13. Birthplace St. Marys Co. Md.14. Maiden name Florence Hill15. Birthplace St. Marys Co. Md.

18. Informant.....

Address

17. (Burial, cremation, or removal. Which?) Date thereof Jan. 13-45
(month) (day) (year)Cemetery or crematory Holy CrossLocation Great Mills, Md.18. Funeral director P.B. RobinsonAddress Leonardtown Md.19. Jan. 12-45
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys
 City or town Rural Callaway
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH January 11 1945 at 9 P.M.21. I CERTIFY that death occurred on the day above stated; that I attended deceased from Jan. 6 1945 to Jan. 11 1945 and that I last saw him alive on Jan. 6 1945.Immediate cause of death Bronchitis - pneumoniaDue to Tracheo - pharyngitisDue to /Other conditions /

(Include pregnancy within 8 months of death)

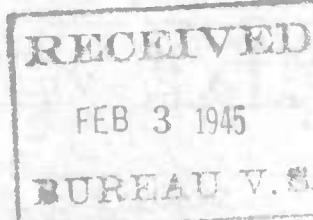
Major findings of operations /Date of op. /

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide / Date of /Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) /Means of injury / Injured at work? /23. SIGNATURE P.B. Robinson M.D.
M. D. or other M.D.Date signed 1-12-45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

00813

CERTIFICATE OF DEATH

Reg. Dist. No. 78 ✓

1. PLACE OF DEATH:

County..... St. Marys¹City or town..... U.S.N.A.S., Patuxent River, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

SOUZA, Anthony Francis

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.) 11 March 1926

8. AGE: Years Months Days If less than one day
18 18 9 29 hrs. min.9. Birthplace..... Bridgewater, Massachusetts
(Town, county, and state)

10. Usual occupation..... Sailor

11. Industry or business U. S. Navy

12. Name..... Unknown

13. Birthplace.....

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... U.S. Navy

Address.....

17. Transportation Date thereof..... (month) (day) (year)
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Bridgewater, Mass.

Location.....

18. Funeral director..... G.B. Robinson

Address..... Acadiana Pte. MD

19. 1/13 85th Anniversary

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Massachusetts County.....City or town..... Bridgewater
(If outside city or town limits, write RURAL and give nearest town)Street No..... 16 Beebe Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 10 January 19..... at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
not attended dead 19..... to 19.....

and that I last saw him on 10 January 19.....

Immediate cause of death..... Injuries, multiple, extreme, including complete decapitation.

Due to..... Plane crash

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 1-10-45

Where did injury occur? Chesapeake Bay, St. Marys, Maryland
(City or town) (County) (State)

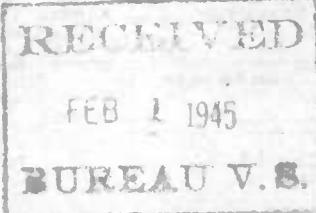
Injured at home, farm, industry, public place (where?) Duty flight

Means of injury Plane crash Injured at work? Yes

23. SIGNATURE..... Julian Love

JULIAN LOVE, Captain (MC) U.S.N. M.D. or other

Address..... USNAS, Patuxent River, Md. Date signed 1-13-44



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2402

00814

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

county St. Mary's U.S.S. VALENCIA (AKA 81)

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred:

U.S.S. VALENCIA (AKA 81)

How long in hospital or institution?

7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mass.

County.....

City or town New Bedford

(If outside city or town limits, write RURAL and give nearest town)

Street No. 323 Cedar St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Czeslaw John TARADEJNA

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

May 8, 1914

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

30

8

16

hrs.

min.

9. Birthplace New Bedford, Mass.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

U. S. Navy

MOTHER FATHER

12. Name Ignacy Taradejna

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant U. S. Navy

Address

Baltimore River, Md.
Transportation Date thereof 1/23/45
(Burial, cremation, or removal, which?)

Cemetery or crematory

New Bedford
Massachusetts

Location

J.B. Johnson

18. Funeral director

Address

Leonardtown, Md.

19.

19

(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1945 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1945, to January 24, 1945,

and that I last saw him alive on January 24, 1945.

Immediate cause of death Streptococcus

Infection.

DURATION

Due to.....

Due to.....

Other conditions Abscess of the Brain

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

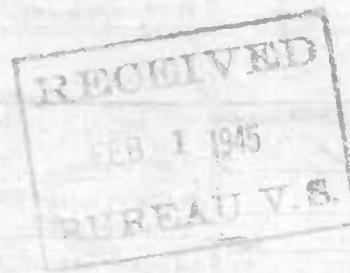
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address H.H. Valencia Date signed 1/24/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00815

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County..... St. Marys.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 hours.....

Hospital, institution, or street address where death occurred:

Dispensary, NAS, Patuxent River, Maryland.....

How long in hospital or institution?..... 27 hours.....

3. (a) FULL NAME

Baby Boy WALSH

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 8 January 1945

8.(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
		10	hrs. min.

9. Birthplace..... NAS, Patuxent River, Maryland
(Town, county, and state)

10. Usual occupation..... infant, premature

11. Industry or business

12. Name..... Carroll Arthur Walsh

13. Birthplace..... Nampa, Idaho

14. Maiden name..... Amy Lee Garrison

15. Birthplace..... Tawanda, Kansas

16. Informant..... Father

Address..... ATB, Solomons, Maryland

17. Burial Date thereof..... 1/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oaklawn Hill

Location..... Valley Lee, Sqrd.

18. Funeral director..... G. F. B. - Robinson

Address..... Hanovertown, Md.

110 45 Canalee

19. (Date rec'd by registrar)..... 19..... Registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Calvert.....

City or town..... Solomons..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 1945 at 1:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 P.M. on 8 Jan. 1945, to 1:05 A.M. 9 Jan. 1945, and that I last saw him alive on 8 January 1945.

Immediate cause of death.....

Prematurity

Erythroblastosis foetalis

Due to.....

parental blood factors

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... To be reported

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

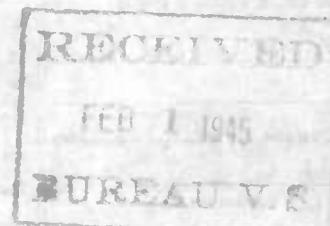
23. SIGNATURE..... W.O. TIRRELL, Jr. Lt. (MC) USNR

M. D. or other

Address..... NAS, Patuxent River, Md..... Date signed 1/9/45.....

RECEIVED TO DEPARTMENT OF STATE - WASH. D.C.

RECEIVED TO STATIONERY



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00816 8

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: St Mary's Hospital
 County.....
 City or town..... Leonardtown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Md. County..... St. Mary
 City or town..... Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Naval Air Base
 (If rural, give LOCATION)

3. (a) FULL NAME

Willie Lee Willis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Feb 5, 1922

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
22			hrs. min.

9. Birthplace..... Sumter, S.C.
 (Town, county, and state)

10. Usual occupation..... Fireman

11. Industry or business..... Naval Air Base Cedar Pt.

12. Name..... Herbert Parr

13. Birthplace..... S.C.

14. Maiden name..... Rosa Willis

15. Birthplace..... Sumter, S.C.

16. Informant..... Rosa Willis

Address 523 Bungle, Sumter, S.C.

17. Burial..... Date thereof Jan 10, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Sumter

Location..... South Carolina

18. Funeral director..... Mrs. Katie R. Williams

Address 322 N. Schaefer St.

19. (Date rec'd by registrar) 1/9 1945 A. W. Didur
 (Date rec'd by registrar)**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... Janury 5 1945, a. 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 1944, to Jan. 5 1945

and that I last saw h. in alive on Jan. 3 1945

Immediate cause of death.....

Acute Pneumonory Tuberculosis 5 weeks

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

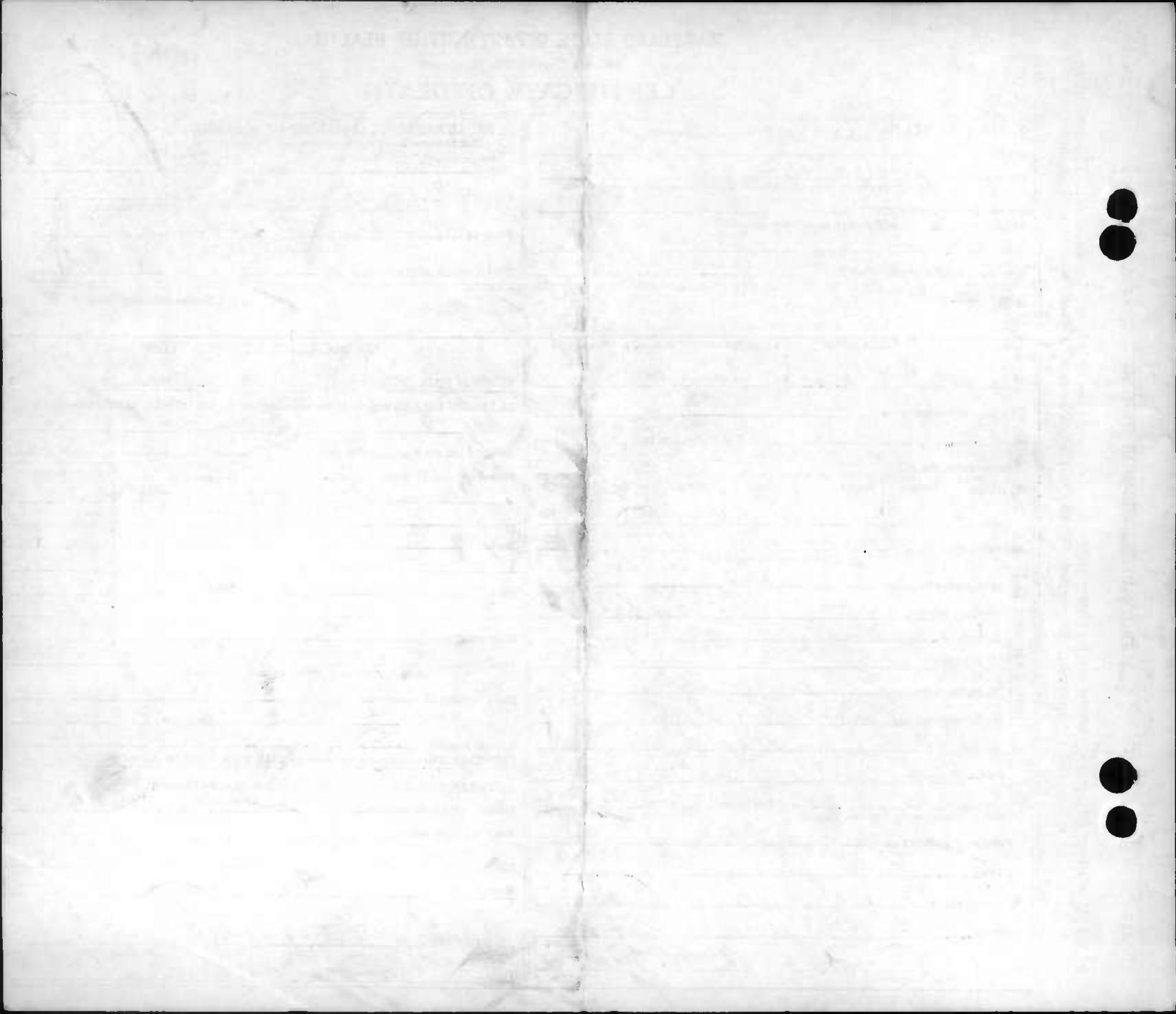
Means of Injury

Injured at work?

23. SIGNATURE..... Mr. H. H. Jackson

M. D. or other

Address..... Beaufort, S.C. Date signed 1-6-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10-17

00817

CERTIFICATE OF DEATH

Reg. Dist. No. 281

M

1) MARGIN RESERVED FOR BINDING

1)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County St. Marys
 City or town Rural Great Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary N. Bean Wise

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female	white	widowed
--------	-------	---------

6.(b) Name of husband or wife

James Wise

7. Birth date of deceased (mo., day, yr.)

Jan. 26 18666.(c) If alive, give age deceased years

8. AGE:

Years	Months	Days	If less than one day
-------	--------	------	----------------------

78	11	23	hrs.	min.
----	----	----	------	------

9. Birthplace

Germansville Md

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER	FATHER
--------	--------

12. Name George Bohannon

MOTHER	FATHER
--------	--------

13. Birthplace Maryland

MOTHER	FATHER
--------	--------

14. Maiden name Maria Yeater

MOTHER	FATHER
--------	--------

15. Birthplace Maryland

MOTHER	FATHER
--------	--------

16. Informant Mrs. Pembroke Moore

MOTHER	FATHER
--------	--------

Address Great Mills Md

MOTHER	FATHER
--------	--------

17. Burial St. Michaels

MOTHER	FATHER
--------	--------

Cemetery or crematory Ridge Md

MOTHER	FATHER
--------	--------

Location Leonardtown Md

MOTHER	FATHER
--------	--------

18. Funeral director To L. Mattingly Sons

MOTHER	FATHER
--------	--------

Address Leonardtown Md

MOTHER	FATHER
--------	--------

19. 1-19-1945

(Date rec'd by registrar)

By Mary N. Bean M.A. Registrar

Total

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. MarysCity or town Rural Great Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1945 at 11:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1943 to Jan 18 1945 and that I last saw h.e. alive on Jan 18 1945

Immediate cause of death

Carcinoma of throat

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

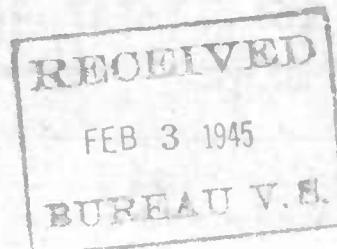
23. SIGNATURE Patricia M.A.

M. D. or other

Address Great Mills Md Date signed 1-19-45

RECEIVED BY THE UNITED STATES GRANT TEAM

THE UNITED STATES OF AMERICA



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

00818

Reg. Dist. No. 281

1. PLACE OF DEATH:

County.....*St. Mary's*
 City or town.....*Rural Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Infant Young

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
<i>Male</i>	<i>Black</i>	<i>Single</i>		
6.(b) Name of husband or wife.....				
7. Birth date of deceased (mo., day, yr.)		8.(c) If alive, give age.....years		
8. AGE:	Years	Months	Days	If less than one day
			hrs.min.

B. Birthplace.....*Leonardtown, Md.*
(Town, county, and state)10. Usual occupation.....*nurse*

11. Industry or business.....

MOTHER FATHER	12. Name..... <i>Margaret E. Young</i>
	13. Birthplace..... <i>Leonardtown Md</i>
	14. Maiden name..... <i>Catherine E. Curtis</i>
	15. Birthplace..... <i>Leonardtown Md</i>

16. Informant.....*Catherine Young*Address.....*Leonardtown Md.*17. Burial.....*Burial* Date thereof.....*Jan. 29 - 45*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....*Home garden*Location.....*Millers Neck*18. Funeral director.....*George Young*Address.....*Leonardtown Md*19. *Jan. 28 - 45* (Date rec'd by registrar) Off. *Great Mills, Md.* Registrar Local

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*St. Mary's*
 City or town.....*Rural Leonardtown*
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*January 27 1945* at *6:05 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 27 1945 to *Jan. 27 1945* and that I last saw h. in alive on *Jan. 27 1945*

Immediate cause of death.....

Premature birth (5 mos.)

DURATION

Due to.....

undetermined

Due to.....

Other conditions.....

(Includes pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*pg Beany M.D.* M. D. or otherAddress.....*Great Mills, Md.* Date signed *1-28-45*

